EMS VARIANCE/EXEMPTION APPLICATION FOR PROVIDERS
VIRGINIA DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
(Please print or type all information)

☐ **VARIANCE** ☐ **EXEMPTION**

Date: Click here to enter a date.

Name of Applicant: Click here to enter text. SSN: Click here to enter text.

Address: Click here to enter text.

Click here to enter text.

Click here to enter text.

Primary Phone: Click here to enter text. Secondary Phone: Click here to enter text.

Email Address: Click here to enter text.

EMS Agency Affiliation (Name and number): Click here to enter text.

Section(s) of the applicable Rules & Regulations:

Click here to enter text.

Reason for the Request, including any extenuating circumstances (be specific):

Click here to enter text.

Submit written documentation for any matters related to medical situations (including proof of medical treatment from a physician) or military mobilizations.

If variance, period of time needed to complete requirements: Click here to enter text.

Name of Individual Completing form:

Click here to enter text. _____

Signature

OMD Approval: Click here to enter text. _____

Signature

Chief Officer: Click here to enter text. _____

Signature

Health Department Use Only:
Date Received:_____ Reviewed By:_____

EMS 6036 Revised: 06/2011

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Form Completion Check Sheet

1. Form completed in its entirety and signed: ☐ Yes ☐ No
2. Signature of EMS agency Operational Medical Director - Required if EMS provider is affiliated with an EMS agency: ☐ Yes ☐ No
3. Signature of Chief Officer of EMS agency – required if EMS provider is affiliated with an EMS agency: ☐ Yes ☐ No
4. Supporting documentation (medical documentation, military orders, etc): ☐ Yes ☐ No

Code of Virginia § 32.1-111.9 Applications for variance or exemptions

(http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+32.1-111.9)

IMPORTANT

A. Form must be completed in its entirety, submitted and received by OEMS prior to the expiration of the EMS certification, license or testing eligibility.

B. Failure to complete this form in its entirety will delay the processing of the request.

Health Department Use Only:
Date Received:_____ Reviewed By:_____